

<b>Case Number:</b>	CM14-0029877		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	04/13/2013
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 54-year-old male who sustained an industrial injury on 4/13/13, relative to continuous trauma. The 6/13/13 cervical MRI impression documented a 3 mm C5/6 posterior disc protrusion with encroachment on the subarachnoid space and borderline touching of the cord. There were bilateral facet joint arthritic changes, and 3-4 mm anterior disc protrusion/osteophyte formation complex. At C6/7, there was a 2 mm posterior disc protrusion with encroachment on the subarachnoid space, but not the cord. There was encroachment on the foramina and exiting nerve roots bilaterally, and bilateral facet joint arthritic changes. There was a 3-4 mm anterior disc protrusion. At C7/T1, there was a 3 mm posterior disc protrusion with encroachment on the subarachnoid space, but not the cord. There was encroachment on the foramina and exiting nerve roots bilaterally, and bilateral facet joint arthritic changes. There was a 3 mm anterior disc protrusion. The 6/19/13 electrodiagnostic report revealed mild bilateral carpal tunnel syndrome and no evidence of acute cervical radiculopathy. The 12/10/13 treating physician report cited continued symptoms in the cervical spine, chronic headaches, tension between the shoulder blades, and migraines. He had failed conservative treatment with activity modification, physical therapy, and pain management, including a cervical epidural block. A 50% reduction in hand numbness was reported following cervical epidural steroid injection on 10/18/13. Cervical spine exam documented cervical paravertebral and upper trapezius muscle tenderness and spasms, positive axial loading and Spurling's tests, painful and restricted range of motion, and C5 to C7 dysesthesia. Shoulder exam documented tenderness, pain with terminal motion, and positive impingement tests. Bilateral exam documented positive Tinel's and Phalen's

tests, and dysesthesias at the radial digits. Cervical spine x-rays showed spondylosis that was quite significant at C5 through C7, and to a lesser extent at the C7/T1 level. The diagnosis was cervical discopathy, and bilateral carpal tunnel syndrome/double crush syndrome. The treatment plan recommended anterior cervical microdiscectomy with implantation of hardware at the level of C5 through C7, possible C7/T1. The 1/20/14 treating physician report cited persistent neck pain aggravated by repetitive motions of the neck, prolonged positioning of the neck, pushing, pulling, lifting, forward reaching, and working at or above shoulder level. He had upper extremity pain. Exam was unchanged. The treatment plan indicated authorization was pending for recommended cervical spine surgery. The 2/25/14 utilization review non-certified the request for C5-C7, possible C7/T1 anterior cervical discectomy and implantation of hardware as there was no significant pathology noted at C7/T1 and multilevel implantation of hardware (artificial disc replacement) was not supported by guidelines and contraindicated given the existing facet pathology.

### **IMR ISSUES, DECISIONS AND RATIONALES**

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **C5-C7, Possible C7-T1 Anterior Cervical Microdiscectomy with Implantation of Hardware: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Neck and Upper Back Chapter, Procedure Summary (last updated 12/16/13), Discectomy/Laminectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: Discectomy-laminectomy-laminoplasty; Disc prosthesis; Fusion, anterior cervical.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines provide a general recommendation for cervical decompression and fusion surgery, including consideration of pre-surgical psychological screening. MTUS guidelines do not address artificial disc replacement. The Official Disability Guidelines (ODG) provides specific indications. The ODG recommend anterior cervical fusion as an option with anterior cervical discectomy if clinical indications are met. Surgical indications include evidence of motor deficit or reflex changes that correlate with the involved cervical level, abnormal imaging correlated with clinical findings, and evidence that the patient has received and failed at least a 6-8 week trial of conservative care. The Official Disability Guidelines indicate that disc prostheses are under study. While comparative studies with anterior cervical fusion yield similar results, the expectation of a decrease in adjacent segment disease development in long-term studies remains in question. And there is an additional problem with the long-term implications of development of heterotopic ossification. Additional studies are required to allow for a recommended status. The general indications for currently approved cervical-ADR devices (based on protocols of randomized-controlled trials) are for patients with intractable symptomatic single-level cervical DDD who have failed at least six weeks of non-operative treatment and present with arm pain and

functional/ neurological deficit. Guideline criteria have not been fully met. This patient presents with multilevel cervical degenerative disc disease with imaging evidence consistent with nerve root compression at the requested levels. Clinical exam findings are consistent with imaging. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, surgical indications do not support the use of disc prosthesis at multiple levels or in the presence of multilevel cervical degenerative disc disease. Therefore, this request is not medically necessary.

**Inpatient Hospital Stay (2-3 days): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Neck and Upper Back Chapter, Procedure Summary (last updated 12/16/13), Hospital Length of Stay (LOS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: Hospital length of stay (LOS).

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Co-Surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeons, Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics, Role of the First Assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, (<http://www.cms.gov>).

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Purchase of Cervical Collar: Minerva Mini Collar: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Neck and Upper Back Chapter, Procedure Summary (last updated 12/16/13), Cervical Collar For Post Operative Use.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Cervical collar, post-operative (fusion).

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Purchase of Cervical Collar: Miami J Collar with Thoracic Extension: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Neck and Upper Back Chapter, Procedure Summary (last updated 12/16/13), Cervical Collar for Post-Operative use.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Cervical collar, post-operative (fusion).

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Bone Stimulator: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin Number 0343: Bone Growth Stimulators: Electrical Stimulation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: Bone-growth stimulators (BGS).

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Medical Clearance: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Last Updated 05/10/2013, Preoperative Testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative Evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.